FACILITY / AGENCY APPLICATION

ORGANIZATIONAL PROVIDER IDENTIFYING INFORMATION					
Legal Name					
Parent Company (if applicable)					
DBA (Identifying) Name					
Administrative Address					
City, State, Zip				County	
Administration Phone		Admitting Phone		Secure Fax (for certifications)	
Website					
Tax Identification Number					
Billing/Remit Address					
City, State, Zip					

ORGANIZATIONAL PROVIDER CONTACT INFORMATION			
	Name	**Phone**	**Email Address**
Primary Contact			
Signatory Contact			
Contracting Contact			
Administrator / Roster Contact			
Business Office Manager			
Director of Clinical Services			
Medical Director			
Name of Chief Executive Officer			

ACCREDITATION				
		ISSUE DATE	**EXPIRATION DATE**	**NOT APPLICABLE**
JCAHO ACCREDITATION				
CARF ACCREDITATION				
AOA ACCREDITATION				
COA ACCREDITATION				
Please list other Accreditation held by your organization.				

LICENSURE / CERTIFICATION				
	ENTITY ISSUING LICENSE OR CERTIFICATE	**TYPE OF LICENSE OR CERTIFICATE**	**LICENSE NUMBER**	**EXPIRATION DATE**
1.				
2.				
3.				
4.				

Does the Organizational provider state licensure/certification include a site visit by the State? ☐ **Yes** ☐ **No**

If Yes, please attach a copy of the audit completed by the State with this application.

MEDICARE / MEDICAID

	NUMBER	ISSUE DATE	EXPIRATION DATE	NOT APPLICABLE
Medicare ID Number				
Medicaid ID Number:				
National Provider Identifier (NPI)				

Are you registered as a Federally Qualified Health Center **(FQHC)**?	**Yes**		**No**	
Is your Agency considered a Community Mental Health Center (CMHC)?	**Yes**		**No**	
Is your Agency considered a State Licensed OP Clinic - (Non CMHC)?	**Yes**		**No**	
Is your Agency considered a Community-based Service Agency?	**Yes**		**No**	
Is your Agency considered a School-based Health Center?	**Yes**		**No**	
Is your Agency considered a Rural Health Clinic?	**Yes**		**No**	

MANAGED CARE PARTICIPATION

List the names of any managed care companies with whom you currently contracted with:

1.		How Long?	
2.		How Long?	
3.		How Long?	

GENERAL / PROFESSIONAL LIABILITY

Please attach current certificates for two types of liability insurance information. UBH insurance requirements are as follows:

For facilities/programs **with** an acute inpatient component:

professional/general liability — $5,000,000/$5,000,000 minimum coverage

For facilities/programs **without** an acute inpatient component:

professional liability — $1,000,000/$3,000,000 minimum coverage

comprehensive general liability — $1,000,000/$1,000,000 minimum coverage

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts stated above.

Please complete the enclosed Malpractice Questionnaire, answering number I or II.

LEGAL STATUS

1. Has the Organizational Provider or any party owning or controlling 10% or more of your company have knowledge of or been subject to disciplinary action, criminal/ethical investigations or convictions; such as but not limited to revocation, suspension or restriction of its license; Medicare/Medicaid provider status; certification or accreditation status (JCAHO, P.R.O, CARF, COA, AOA); bankruptcy, insolvency or assignment of creditor proceedings?

☐ Yes* ☐ No

**If yes to the above, please attach a brief explanation for each incident.*

SIGNATURE

I hereby certify that all of the responses and information provided pursuant in this application are complete, true, and correct to the best of my knowledge and belief. I further warrant that facility's applicable licensure(s) is current and free of sanction or limitation. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Signature

Name please type or print

Title please type or print **Date**

Acceptance into UBH's provider network is contingent upon the applicant Facility's meeting UBH credentialing standards and subject to review and approval by the UBH Credentialing Committee. As a reminder, we consider accurate and up-to-date credentialing documents to be a vital part of maintaining a quality network. The need to keep this information current in our files means that we will approach you to request this documentation throughout the life of the contract between the parties. These requests can be expected approximately every 36 months. We understand that complying with this request can be time consuming, but it is required for your continued participation in the UBH network. The information requested is required in order to comply with UBH credentialing standards. Additionally, the information you provide will help ensure the accuracy of claims payment.

DOCUMENTATION

Please Provide the Following Documents:

- ☐ Current State License(s)/ Certificate(s) for all behavioral health services you provide, i.e. psychiatric, substance abuse, residential, intensive outpatient, etc. A18 - include all documentation for multiple facility locations
- ☐ JCAHO/ CARF/AOA/COA Accreditation status
- ☐ Professional and General liability insurance certificates showing limits, policy number(s) and expiration date(s). If self insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.
- ☐ W9 form (if multiple tax ID numbers used, one W9 must be submitted for each ID number)

Other Documents:

- ☐ Malpractice Questionnaire
- ☐ Staff Roster for all behavioral health staff involved with your programs. Please list their degrees, licenses and/or certificates. We do not need an actual copy of their licenses or certifications.
- ☐ Daily Program Schedule(s) - include an hour-by-hour schedule showing a patient's daily treatment for each level of care you provide including weekend scheduling where appropriate.
- ☐ Program Description - including any specialty program descriptions
- ☐ OP Clinic Attachment (only necessary if facility has outpatient clinic services)

Policy and Procedures:

- ☐ Policy and Procedure on Intake/Access Process to Behavioral Medicine
- ☐ Policy and Procedure on Intake/Access Process if done through E.R.
- ☐ Policy and Procedure on Holds/Restraints
- ☐ Policy and procedure for Discharge Planning
- ☐ Quality Improvement Plan